

# Northwest Houston Neurology, PA

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## THIS SECTION REFERS TO THE PATIENT ONLY

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Sex \_\_\_ D.O.B. \_\_\_\_\_ Marital Status \_\_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Home Ph# \_\_\_\_\_ Work Ph# \_\_\_\_\_ Cell Ph# \_\_\_\_\_

Email address \_\_\_\_\_ Preferred method of contact \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Employer Ph# \_\_\_\_\_

Race  American Indian or Alaska Native  Asian  Native Hawaiian  African American  White  
 Hispanic  Other Pacific Islander  Other  Refused to Report

Ethnicity  Hispanic or Latino  Non-Hispanic or Latino Language \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation to patient \_\_\_\_\_ Ph# \_\_\_\_\_

**If a MINOR, complete with PARENT'S info – If MARRIED, complete with SPOUSE'S info**

**Mother's/Spouse's Name** \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Email Address \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ Ph# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Ph# \_\_\_\_\_

**Father's Name** \_\_\_\_\_ D.O.B. \_\_\_\_\_

SS# \_\_\_\_\_ DL# \_\_\_\_\_ Email Address \_\_\_\_\_

Address (if different than above) \_\_\_\_\_ Ph# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer Ph# \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company \_\_\_\_\_ Customer Service # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Employer \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Subscriber Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

## ADDITIONAL INFORMATION

Name and Phone Number of Referring Provider \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Pharmacy Ph# or Address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Name of family members that are also patients here \_\_\_\_\_

I, the insured person for this account, do assign the collection of benefits to Northwest Houston Neurology, PA. I give my permission to release medical information needed to process medical claims. I understand that Northwest Houston Neurology, PA will attempt to collect payment from my insurance company, yet I am ultimately responsible for the payments on this account. Any balance unpaid by my insurance company after 60 days of filing can be billed to me for payment. I have been provided a copy of the office policies.

**Signature of Patient/Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

# Northwest Houston Neurology, PA: Office & Financial Policy

Thank you for choosing Northwest Houston Neurology! Our goal is to provide quality medical care and to maintain a positive patient-physician relationship. Providing you with our office policy in advance encourages the flow of communication and enables us to achieve our goal. Please review our policy carefully.

## Appointments

- All patients must complete the patient information forms prior to seeing the physician. We will require copies of your insurance card and photo identification. You may be asked to update this information annually.
- If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.
- We value the time we have set aside to spend with you. If you are unable to keep an appointment, please provide a 24 hour notice so that we may offer this time to another patient. If you do not provide notice, you will be charged a No Show Fee.

## Financial Policy

- Payment in full is due at the time services are rendered, including past due balances.
  - Patient share estimates (copayments, deductibles, co-insurances) are due in full at the time of service. An estimate is only an estimate and never a guarantee of exact fees. Your final share will be determined once the insurance processes the claims. Patient overpayments will be refunded after the insurance pays and upon the patient's request.
  - Our office verifies insurance coverage as a courtesy; however, payment is not guaranteed. Claims are processed by the insurance company. It is the insured's responsibility to understand the benefit plan with regards to covered services and participating facilities. The patient will be billed directly for any services not covered by insurance.
  - If our office is unable to verify the insurance coverage, the patient is financially responsible for the visit.
  - It is your responsibility to update us with current insurance information. If the insurance company you designate is incorrect, you may be held responsible for charges due to timely filing requirements.
  - If the insurance company requires a referral and one is not on file, the patient is financially responsible for the visit.
  - We are happy to help assist with insurance questions. However, specific coverage issues or claims processing questions should be directed directly to your insurance company.
- We do not file claims to workers' compensation or automobile insurance. The patient is responsible for payment in full. We will provide receipts so that you may file claims for reimbursement.
- Your insurance company may request that you supply information to them directly in order to process claims (i.e. coordination of benefits, pre-existing info.). It is your responsibility to comply in a timely manner.
- If the patient is a minor, in cases of divorce or separation, the person requesting services is responsible for the payment due at the time of service and for any past due balance.
- We accept cash, check, and most major credit cards. A \$30 fee will be assessed for returned checks. Checks returned due to stop payment may lead to dismissal from the practice.
- Statements are sent out monthly and payment is appreciated within 10 days upon receipt. Accounts with balances over 90 days with no activity can be turned over to collections and dismissed from our practice.

## Referrals, Test Orders, Prescriptions

- NWHN may refer patients to outside facilities for further evaluation or testing. Due to the complex nature of medical insurance contracts, we cannot know for sure if that facility is in-network with your particular plan. It is the patient's responsibility to contact the facility and/or insurance company to determine the network status. If the facility is out-of-network, the patient may choose to go elsewhere. Contact your insurance company a list of in-network facilities.
- Some tests ordered by our physicians may require authorization from your insurance carrier. If this is the case, please allow 10 business days for our office to obtain the authorization.
- Prescriptions and Refills
  - **We do not dispense written prescriptions.** We will send prescriptions electronically or call in prescriptions directly to the pharmacy on file.
  - Controlled Substances: These prescriptions are not sent electronically. Some can be called in to the pharmacy while others must be picked up by an authorized adult. Monthly or quarterly visits are required.

## Forms

- Forms will be completed during an appointment. Please bring forms to the visit and complete everything other than the section required by the physician. We reserve the right to decline completion of these types of forms.
- There is a fee for the completion of medical forms and for medical letters written by physicians.

## Transfer of Records

A fee will be assessed for a copy of your medical records. A release of information must be signed. If you transfer to another physician or we refer you to another physician, we will send that physician a copy of your last visit and pertinent records free of charge. Please allow 10 business days for transfer of records.

**Non Compliance with our policy can lead to dismissal from the practice. Examples of this include noncompliance with physician orders, appointments, disruptive behavior, etc.**

# Summary of Notice of Privacy Practices

## Purpose

This Notice gives you information required by law about the duties and privacy practices of Northwest Houston Neurology, PA (NWHN) to protect the privacy of your protected health information (“PHI”), as the term is defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), in providing for your medical treatment and needs. **It describes how medical information about you may be used and disclosed and how you can access this information.** This Notice of Privacy Practices is a summarized version of our Full Notice of Privacy Practices available in our office.

## Northwest Houston Neurology Responsibility

We as the provider have the responsibility to make you aware of HIPAA and how it relates to you and your treatment. We are required to supply you with a written copy of the Summary of Notice of Privacy Practices and to make the full-length version of the Notice for Privacy Practices available to you. We also have the responsibility to accept formal complaints and may not retaliate against or attempt to dissuade you in that instance. We do, however, reserve the right to make changes or amendments to the Notice, but we will make any revisions known as soon as they are in place and provide you with a written copy of the revised notice.

## Patient Rights Regarding Medical Information

HIPAA allows you, the patient, various rights in regards to your PHI. To exercise any of the following rights, you must submit a written request to the office:

- **Inspect and copy.** You have the right to inspect and copy your health information unless in a circumstance prohibited by law. You may be charged a fee by NWHN, in accordance with Texas Law.
- **Request Amendment.** If believe the PHI maintained is wrong, you may request an amendment. NWHN is not required to agree with this request.
- **Request Restrictions.** You may request limitations on how NWHN uses and/or discloses your PHI. NWHN does not have to agree to the request. If NWHN agrees, we will comply with your request unless there is an emergency or it is otherwise required by law.
- **Receive confidential communications.** You may request that NWHN communicate with you in a certain manner or a certain location. You must be specific, otherwise, any contact information provided by you will be utilized including addresses, phone numbers or email addresses.
- **Accounting Disclosures.** You may request a list of disclosures made by NWHN of your PHI to persons or entities other than for the purpose of treatment, payment of health care operations, or pursuant to your specific authorization.
- **File a complaint with NWHN or the Secretary of Health and Human Services** if you feel your rights have been violated.

## Use and Disclosure of Your Protected Health Care Information

The following is a list of ways NWHN may use and disclose your PHI. Not every possible use or disclosure in any given section is listed. However, all of the ways NWHN is permitted to use and disclose your PHI will fall within one the categories:

**Treatment** NWHN may use your PHI to provide you with medical treatment or services. NWHN may disclose your PHI to doctors, nurses, technicians, pharmacists, medical students or other members of your health care team.

**Payment** NWHN may use and disclose your PHI to obtain payment from your insurance company or third party. NWHN may also disclose your PHI to other health care providers to assist those providers in obtaining payment from your insurance company or third party.

**Health Care Operations** NWHN may use and disclose your PHI for routine health care operations.

**Appointments and Alternatives** NWHN may use and disclose your PHI to contact you to provide appointment reminders, prescriptions refill reminders, and other communications regarding your case management or health care conditions.

**Business Associates** NWHN may disclose your PHI to NWHN business associates in order to carry out treatment, payment, or other healthcare operations. Under certain circumstances, we may use and disclose PHI for research purposes.

**Health Oversight Activities** NWHN may disclose your PHI to a health oversight agency or entity for activities authorized by law, such as audits, investigations, and licensure.

**Public Health Activities** As required by law, NWHN may disclose your PHI for public health activities.

You may revoke any prior authorization in writing. A written revocation will not apply to any previous use or disclosure of PHI made in good faith under a prior authorization.

# Northwest Houston Neurology, PA

## Patient Privacy Questionnaire (HIPAA)

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Parent or Legal Guardian Name

\_\_\_\_\_  
DL Number

**This signed Privacy Form will remain in your file and considered current. If there are any changes, you must notify our office and complete another form.**

1. Please list other persons, if any, whom we may inform about the patient's general medical condition and diagnosis (including treatment, payment, and health care operations):

Name and Relationship:

Phone:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Please list any persons that can consent to treatment and medical care for the patient when the legal guardian is not available to give consent:

Name and Relationship:

Phone:

\_\_\_\_\_

\_\_\_\_\_

3. Please list any persons that are authorized to pick up paperwork or prescriptions for the patient:

Name and Relationship:

Phone:

\_\_\_\_\_

\_\_\_\_\_

4. Please list other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name:

Phone:

\_\_\_\_\_

\_\_\_\_\_

The patient may be contacted by our office with appointment reminders, healthcare treatment options or other health services. We will limit the amount of information left in messages to just the information necessary to confirm the appointment or to request a return call. We may contact you by mail, phone, voicemail, text or email, using any information that you provided. **You may request that NWHN communicate with you in a certain manner. You must be specific and provide this request in writing.**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

# Northwest Houston Neurology, PA

## Patient Consent Form

Name of Patient \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_  
Name of Patient's Representative \_\_\_\_\_ Relation to patient: \_\_\_\_\_

### Notice of Privacy Practices Acknowledgment

I hereby consent to the use or disclosure of individually identifiable or protected health information (PHI) by Northwest Houston Neurology (NWHN) in order to carry out treatment, payment, or health care operations. I acknowledge that NWHN has provided a copy of the Notice of Privacy Practices as required by law.

NWHN reserves the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time and must notify the patient. The patient retains the right that NWHN further restrict how the PHI is used or disclosed. NWHN is not required to agree to such requested restrictions; however, if NWHN does agree to Patient requested restriction(s), such restrictions are then binding on NWHN. The patient retains the right to revoke this Consent. Such revocation must be submitted to NWHN in writing. The revocations shall be effective immediately except to the extent that NWHN has already taken action in reliance on the Consent.

NWHN may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that NW Houston Neurology PA is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, NWHN has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that NW Houston Neurology PA is required by law to treat individuals).

### General Consent to Treat

I authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Northwest Houston Neurology and their designated associates believe are necessary. I understand that by signing this form, I am giving permission to the doctors or other health care providers in this medical office to provide treatment as long as a physician / patient relationship exists, or until I withdraw my consent in writing. **Treatment of Minor**, if applicable: I, as the parent/legal guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so.

### Office Policy and Financial Policy

I acknowledge that I been provided a copy of NWHN's Office Policy and Financial Policy and I understand the terms.

### Electronic Prescribing

I voluntarily authorize Northwest Houston Neurology to allow E-prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice and review medication history as long as a physician / patient relationship exists, or until I withdraw my consent in writing.

### Voicemail, Texts, and Email Notifications

Northwest Houston Neurology provides courtesy appointment reminder calls/texts/emails and possibly other important calls or reminders that may be placed by a staff member or by using a prerecorded auto messaging system. This information may include PHI. I understand that by signing this form, I give consent to receive such calls/texts/emails at the number/email addresses I have provided unless specific restrictions have been provided in writing.

### Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Northwest Houston Neurology, PA for any services furnished to the patient by the practice. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims benefits.

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I have read this form, had the opportunity to ask questions and accept the terms and conditions as stated.

Patient or Authorized Representative Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Northwest Houston Neurology Medical History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Were you recently seen by our physician in the hospital? Y or N If yes, when and where? \_\_\_\_\_

**Past Medical History**  Headache  Migraine  Stroke/ Mini Stroke  Seizure  Alzheimer's Disease  Tremor  
 Parkinson's Disease  Depression  Anxiety  High Blood Pressure  Diabetes  Heart Disease  Other \_\_\_\_\_

**Past Surgical History** *List ALL Surgeries* \_\_\_\_\_

**Family History**  Headache  Migraine  Stroke/ Mini Stroke  Seizure  Alzheimer's Disease  Tremor  
 Parkinson's  Depression  Anxiety  High Blood Pressure  Diabetes  Heart Disease  Other \_\_\_\_\_

**Social History** Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Assistive Devices (ex: cane) \_\_\_\_\_  
Tobacco Use?  Yes  No, How Much \_\_\_\_\_ Drink Alcohol?  Yes  No, How Much \_\_\_\_\_

**This section is for CHILDREN ONLY. Only complete for patients under 18 years of age.**

**Pregnancy:**  Normal  Problems \_\_\_\_\_

**Delivery**  Normal  C Section  Problems \_\_\_\_\_

**Development:**  Sitting \_\_\_\_\_ Months,  Walking \_\_\_\_\_ Months,  Started Speaking \_\_\_\_\_ Months

## REVIEW OF SYMPTOMS *Please check ALL that apply*

### General

- Neck Pain
- Back Pain
- Weight Gain
- Weight Loss
- Fever

### Head/Neck

- Head Injury
- Vision Problems
- Sore Throat
- Trouble Swallowing
- Hearing Problems

### Cardiovascular

- Chest Pain
- Skipped/Irregular Heartbeat

### Neurologic

- Dizziness
- Numbness / Tingling
- Weakness
- Headaches
- Seizure
- Passing out Spells
- Tremors

### Respiratory

- Shortness of Breath
- Sleep Apnea
- Cough
- Wheezing

### Gastrointestinal

- Abdominal Pain
- Vomiting / Diarrhea

### Genitourinary

- Pain with Urination
- Unable to Urinate
- Involuntary Urination

### Musculoskeletal

- Joint Swelling
- Joint Pain

### Skin

- Rash

### Allergies

- Nasal Allergies

### Sleep

- Awake with Dry Mouth
- Difficulty Concentrating
- Excessive Daytime Sleepiness
- Frequent Awakenings
- Loud Snoring
- Memory Loss
- Morning Headaches
- Need to move legs
- Nervous / Anxious
- Nocturia
- Poor School Performance
- Racing Thoughts
- Reflux at night
- Sleep Talking
- Sleep Walking
- Teeth Grinding
- Unrefreshing Sleep
- Witnessed Apnea

### Psychiatry

- Anxiety
- Depression

# Sleep Questionnaire

Name and DOB: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is your primary sleep concern? \_\_\_\_\_

Have you had a sleep study? Y or N If yes, What kind \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

Have you ever been diagnosed with a sleep problem in the past? Y or N If Yes, what was the diagnosis and the treatment recommended? \_\_\_\_\_

Any other reasons for your visit? \_\_\_\_\_

## SLEEP HABITS

Answer the following questions based on your experience in the last six months, with "night" meaning your major sleep time.

How many hours do you normally sleep? \_\_\_\_ How long does it normally take you to fall asleep? \_\_\_\_

How many times, if any, do you wake up during the night? \_\_\_\_\_

What wakes you? \_\_\_\_\_

Are you usually refreshed after a night of sleep?  Yes  No

Do you feel excessively sleepy during the day?  Yes  No

Do you take naps?  Yes  No If yes, do you feel refreshed after a nap?  Yes  No

## NIGHTTIME BEHAVIORS

Do you snore?  Yes  No

Do you wake up gasping/choking?  Yes  No

Are your bed covers messy when you wake up?  Yes  No

Do your legs jerk at night in bed while you are still awake?  Yes  No

Do you have nightmares or night terrors?  Yes  No

**MEDICATIONS:** Please list all current medications with dosage information.

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**ALLERGIES:** Please list all drug allergies, if any.

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# The Epworth Sleepiness Scale

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Date: \_\_\_\_\_

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

## How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- Chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Dozing = to fall into a light sleep unintentionally

**Write down the number corresponding to your choice in the right hand column. Total your score below.**



Situation	Chance of Dozing Indicate 0, 1, 2, or 3
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

 Total Score: \_\_\_\_\_